will be 66 in 10 years. Natural gas prices soared to triple last year's prices, which caused home heating last year in my area to be a real pain and caused some businesses to go out of business.

No new gasoline refineries built in 10 years; no new nuclear plants licensed in over 10 years. There is new nuclear technology today that is much superior to the past, not nearly as expensive to put in place.

No new coal plants built in 10 years. There is a new one being built in Pennsylvania right now. It is going to be using, again, waste coal that is on top of the ground already.

Gas and electric transmission capacity is overloaded.

Those are some of the problems. Anyone who says we do not have energy problems in this country, we have distribution problems and access problems. As we said in the beginning, for energy to be affordable and available to people and businesses, we need strong, ample supplies of each and every kind of energy. And we need to develop a system that is not so dependent on oil, not so dependent on one fuel, but gives people alternatives. Then people that use a lot of fuel in a business could choose the fuel that is the cheapest for the day.

We have the technology to do it cleanly. We need to, as time goes along, to grow the renewables. I think fuel cells are a great potential. There will be slight growth in wind and solar. I do not think they will be major players. Geothermal has some potential.

None of those will put enough into the system to even take care of our growth in energy needs. Fuel efficiency, conservation and fuel efficiency, can only take up half of the slack of the energy-need growth, so we have to have more energy and a system to deliver it.

Mr. RADANOVICH. I want to thank the President for bringing to the Congress his energy plan, and I hope we pass it tomorrow by wide margins.

Mr. PETERSON of Pennsylvania. I do, too. I thank the gentleman from California, a good friend. So from the east coast to the west coast, we will join hands and hopefully can bring this one home for the people of this country.

I thank all who participated tonight to talk about energy, an issue that is number one in this country and one that I commend President Bush and Vice President CHENEY for having the courage to tackle.

It is our future. Energy is what runs this country; and we must have abundant supplies, a delivery system, and we must use it wisely.

## HMO REFORM AND THE REAL PATIENTS' BILL OF RIGHTS

The SPEAKER pro tempore (Mr. SHUSTER). Under the Speaker's announced policy of January 3, 2001, the gentleman from Pennsylvania (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, this evening I plan to talk about HMO reform and what I call the real Patients' Bill of Rights.

Mr. Speaker, I have been here many times before in the last few weeks and even in the last few years to talk about this issue, because I do think it is so important to the American people. We know about many abuses that have occurred within managed care where people have HMOs as their insurance; and frankly, almost a day does not pass by without somebody mentioning to me the problems that they have had with HMOs.

Over the last few years our concern over this, particularly in our Health Care Task Force on the Democratic side, has manifested itself by supporting a bill called the Patients' Bill of Rights, which is sponsored by the gentleman from Michigan (Mr. DINGELL), a Democrat, the gentleman from Iowa (Mr. GANSKE), and the gentleman from Georgia (Mr. NORWOOD), who happen to be two Republicans.

We had a vote in the House of Representatives in the last session of Congress, at which time almost every Democrat supported the Patients' Bill of Rights, and 68 Republicans also supported it. Unfortunately, the Republican leadership here in the House of Representatives has never supported the bill, and continues to oppose it. Also unfortunately, now President Bush has indicated since he took office his opposition to this legislation.

What is happening now is that we had a commitment from the Speaker to bring up the Patients' Bill of Rights over the last few weeks, and specifically last week; but he announced last week that that vote was postponed and delayed because the votes did not exist for an alternative HMO reform bill sponsored by the gentleman from Kentucky (Mr. FLETCHER).

I hate to say it, Mr. Speaker, but the bottom line is that this alternative Fletcher bill is not a real Patients' Bill of Rights; it is a much weaker version, if you will, of HMO reform. I could make a very good case for saying that it does not accomplish anything at all and continues the status quo.

What we hear today is that the Republican leadership plans to bring up HMO reform on Thursday of this week. In fact, in just a few hours there might actually be a markup in the Committee on Rules on the legislation.

But again, the issue, Mr. Speaker, is what are we going to be able to vote on. Will we be able to vote on the real Patients' Bill of Rights, the Dingell-Ganske-Norwood bill, or are we going to see the Fletcher alternative or some other weakening effort, so we do not have a clean vote on the Patients' Bill of Rights?

Unfortunately, Mr. Speaker, I was reading in Congress Daily, the publication that we receive about what is going on on Capitol Hill. It actually indicates tonight that the Republican plan is to somehow separate out various pieces of the Fletcher bill and propose them as amendments to the real Patients' Bill of Rights.

I do not really know what the Republicans' procedure is going to be; but if this is the case, once again, it is a sort of insidious way of trying to kill the real Patients' Bill of Rights.

The Congress Daily says that ''likely amendments include the Fletcher liability provisions, an access package of proposals seeking to expand insurance, possibly an amendment replacing the bipartisan bill's patient protections with those in the Fletcher bill. Also possible is an amendment to impose caps on medical malpractice awards.''

Let me tell the Members, if any of these things do in fact happen, if this is how the Republican leadership intends to proceed, it once again indicates that they are not in favor of a real Patients' Bill of Rights; that they are not making an effort to bring up this bill, but rather, to kill the bill. I think that is very unfortunate.

I have some of my colleagues here, and I will yield to them. But I just wanted to point out why this Fletcher bill is nothing more than a fig leaf for real HMO reform. It is an effort essentially to peel off votes from the bipartisan Patients' Bill of Rights and undermine the effort to pass real HMO reform this year.

Just as an example, the Fletcher bill contains almost no protections for patients; and it gives patients almost no ability to appeal their HMO's decisions to an independent panel, or to take HMOs to court when they are denied treatment or harmed in any other way.

The real key to HMO reform that is personified, if you will, that is manifested in the Patients' Bill of Rights, the Dingell-Ganske-Norwood bill, is the ability to say that your physician and you as a patient would make decisions about what kind of medical care you get, not the insurance company.

The second most important aspect of the real Patients' Bill of Rights is that if one is denied care because the HMO does not want to give it to us, we have a right to redress our grievances and go to an independent panel, separate and independent of the HMO, to overturn that initial decision. If the Fletcher bill basically does not accomplish those goals, which it does not, then it does not achieve real HMO reform.

I have a lot of other things that I could talk about this evening, and hopefully that we will get to, but I have two of my colleagues here who happen to be both of them from the State of Texas. The State of Texas has a real Patients' Bill of Rights in effect. It has had that since 1997.

I heard some of my Republican colleagues on the other side of this issue say, We do not want the Dingell-Norwood-Ganske bill to pass because if it does, it will mean there will be a lot more lawsuits. The cost of health care will go up, health insurance will go up,

and people will lose their health insurance.

□ 2130

Well, the Texas experience tells us that that is simply not the case. In Texas, over the last 4 years, there have only been 17 suits filed. In Texas, the cost of health insurance has gone up somewhat, but not as much as the national average. So it simply is not the case.

The one thing that I think is most crucial, that I want to mention before I introduce and yield to my two colleagues from Texas, is that what the Fletcher bill does is to preempt a lot of the rights and patient protections that Texas and other States have. Because the Fletcher bill essentially preempts the States' rights and makes all the protections under the Federal law.

What that would mean for States like Texas and New Jersey and about 11 other States that have good patients' bills of rights on the State level, is that they would even be undermined because of what is happening with the Fletcher bill. This is just the opposite of what we would like to see and what we have all been striving for here. It is very unfortunate that we might see this Fletcher bill, or some parts of it, become the focus of debate on Thursday, when this bill comes up.

Mr. Speaker, I wish to yield to a colleague who has been very active on health care issues, not only this one but many of the other health care issues, and who has been speaking out on this issue for a long time, the gentleman from Texas (Mr. TURNER).

Mr. TURNER. Mr. Speaker, I appreciate very much the opportunity to share this hour with the gentleman from New Jersey (Mr. PALLONE) and with my colleague, the gentleman from Texas (Mr. LAMPSON).

We do have a unique perspective on this issue, being from Texas, because Texas was one of the first States in the Nation to pass patient protection legislation. I am sure that there are people tonight listening to us talk about this issue who really wonder what is the big deal about this patients' bill of rights debate in Washington.

We are gathered here tonight on the eve of the consideration of this very important legislation on the floor of this House. We have been at least led to believe that it will be considered either Thursday or Friday. Now, this is not the first time this bill has been on the floor. We considered it over a year ago. We passed it in the House. At that time, the bill died in the Senate.

This year, we have a situation where the bill has passed in the Senate; and it is now up to the House to move on the same legislation. The bill in the Senate, sponsored by Senator MCCAIN, Senator KENNEDY, Senator EDWARDS is almost identical to the bill that we support here in the House, the Norwood-Dingell-Ganske-Berry bill. That is the patients' bill of rights that we believe the American people deserve.

All of this really comes down to one central thought, and that is that when an individual is lying flat on their back in the hospital, fighting for their life, they should not have to be fighting their insurance company. It is important, we believe, to guaranty that patients and their doctors will make the decision about their health care rather than some insurance company clerk in some far away city.

Because managed care companies, HMOs, assume the role of determining whether certain treatment prescribed by an individual's doctor is medically necessary, their opinions often conflict with what a doctor recommends as treatment. Countless doctors have reported to us that they spend hours, literally hours on the telephone arguing with some insurance clerk representing a managed care company trying to get treatment approved, when in many cases we know that mere minutes can mean the difference in life and death.

So the Norwood-Dingell-Ganske bill is a strong piece of legislation designed to ensure certain basic rights and protections for patients: to be sure patients are treated fairly, to be sure they have the opportunity to have the best medical treatment available, to be sure that doctors and not insurance companies practice medicine.

We are very hopeful that this good strong bill will pass this House intact. Now, as the gentleman from New Jersey (Mr. PALLONE) mentioned, there has been another version of the patients' bill of rights sponsored by the gentleman from Kentucky (Mr. FLETCHER). It is a much weaker bill, in my opinion; and it creates many unusual rights for insurance companies, basically designed, in my opinion, to protect them from accountability.

We all believe in this society in personal responsibility, personal accountability. In Texas, we have some good strong patient protection laws. They are working well. What we found in Texas is that when we proposed the legislation in 1995, and I carried that bill as a member of the State Senate, the opponents of the bill said, well, it is going to cause health insurance premium costs to rise and it is going to result in a lot of litigation.

We passed that bill in the State Senate 27 to 3. The House of Representatives in Texas passed it by voice vote. Then Governor Bush vetoed the bill after the legislative session was over. We had no chance to override the veto. The next session of the legislature, in 1997, the identical bill was broken down into four parts. Three of those bills passed and received the Governor's signature. The fourth, passed by an overwhelming majority, related to insurance company accountability and insurance company liability. Then Governor Bush let that one become law without his signature.

Again, the opponents of the bill said it is going to result in higher insurance premiums and it will result in a flood of litigation. We have had that bill in place as law in Texas for 4 years. The record is clear: health insurance rates in Texas have risen at approximately half of the national average. And as we look at the litigation, we see that there has really been very little litigation. What has happened under the bill is that 1,400 patients and their doctors disagreed with the decision of the insurance company about their treatment, and they utilized the protections of Texas law to appeal that insurance company's denial of care.

Fourteen hundred patients in Texas in 4 years have exercised their right to appeal an insurance company decision. In 52 percent of those cases, the patient prevailed. In 48 percent of the cases, the insurance company prevailed. In the cases where the patient was denied the care that the patient and their doctor sought, only 17 lawsuits have resulted. I hardly call that a flood of litigation, as the opponents asserted when the bill was passed in 1997.

The Norwood-Dingell-Ganske-Berry bill is modeled after the Texas law, and it is very similar to laws in many of our States designed to protect patients. So the States are way ahead of the Federal Government in this area. Today, the Texas law stands as a model for the Nation.

Unfortunately, only about half of those enrolled in managed care in Texas are covered by the Texas law. When we passed the legislation in 1997, we really thought all patients in managed care were covered. But it turned out that a Federal Court ruled in a lawsuit involving Aetna Insurance Company, that basically did not like the Texas law, that an arcane Federal law, called the Employee Retirement Income Security Act, passed in 1972, which was a bill that was thought by most people to cover retirement plans, that that also covered managed care insurance plans that operate in more than one State. Thus, the Federal Court ruled that those enrolled in managed care plans that operate in more than one State are not covered by these State patient protection laws. That is about half the people in Texas and in most other States.

So that is why we are having this debate in Washington. That is the genesis. Because we have the unusual situation in law today that because of this 1972 ERISA law, insurance companies who have managed care health plans stand as the only business in America that have no liability for their wrongful and negligent acts.

So the Norwood-Dingell-Ganske bill is designed to fix that. It is designed to say that every managed care insurance company in this country will be personally responsible and personally accountable, and they will be accountable under the Norwood-Dingell-Ganske bill in the same way that every business and individual in this country is accountable under the laws of our land.

So we believe that this bill is essential to eliminate a loophole that exists

in the law that allows managed care health insurance companies to be the only business in America without responsibility.

The Norwood-Dingell bill has many protections for patients. It sets up a review procedure allowing a patient to make an appeal of a managed care health care decision internally within the plan. If they are dissatisfied, they can appeal to an external independent review panel. And if they are dissatisfied with that decision, they have the right every other business and individual in America has, and that is to go to a court of law and have that matter heard by a jury of one's peers.

That is what our legislation is all about. The Fletcher bill denies that. And I am sure that when the Norwood-Dingell-Ganske bill comes to the floor of this House, there will be many who will do the bidding of the managed care industry and try to carve out a special status under law for the managed care industry.

In Texas, in 1995, we had a major piece of legislation commonly referred to as tort reform. It was one of four planks of Governor Bush's platform when he ran and was elected as governor. He pushed that in the legislature and the legislature agreed that we needed managed care reform in Texas. It resulted in some limits on the amount of damages that can be awarded in lawsuits. It limited what we call punitive damages. That is those damages that can be awarded against a defendant when it turns out that that defendant has acted willfully and wrongfully and with malice and has committed such a grievous tortuous act that they should be punished. That is punitive damages.

And in Texas, in the tort reform effort, the governor and the legislature limited the amount of punitive damages that can be awarded in litigation, and it did so by a formula. That formula says that punitive damages shall be kept at whatever a judge or jury finds to be the economic damages, that is the loss in earnings and wages, multiplied by two, plus up to $750,000 of noneconomic damages, pain and suffering and those things that cannot be equated easily to dollars. But that was a cap that the legislature and the Governor signed on punitive damages.

Frankly, what we see in the Fletcher bill is a limit on damages that far exceeds any limit we put in the law in Texas. And when we saw the Governor and the legislature pushing tort reform and limits on punitive damages, nobody suggested that there should be a special carve-out, a special exception, a special rule for the HMOs in the managed care industry. Because common sense would tell us that managed care insurance companies should have the same limits of liability, the same degree of accountability, the same degree of responsibility as any other business or individual when faced with an action in the courts of our land.

The Fletcher bill, and some of the amendments I suspect that will be proposed to the Norwood-Dingell-Ganske bill will attempt to carve out a special status for the managed care health insurance industry. And that is wrong. And I think the American people understand that, and that is why I would call upon this Congress and our President to do what we did in Texas when we pursued tort reform and make sure that everybody is treated the same, everybody is equally accountable, everybody is equally responsible for their negligent acts.

That is why we have insurance, because we all know we can make mistakes in business. We can make mistakes in driving an automobile. That is why we have insurance coverage. And there is absolutely no reason to think that a managed care insurance company should have a special set of rules that applies to them. Furthermore, there is no reason to think that the Federal Government ought to get in the business of creating Federal causes of action when it involves tortuous acts.

In law, we talk a lot about torts. That is intentional injuries. Negligent acts resulting in injury. We talk about contracts.

□ 2145

The Norwood-Dingell-Ganske bill makes the logical distinction between those two things. It says matters of contract, matters of health care plan administration shall be subject to the Federal courts if it is a multistate health insurance plan, but it preserves the historic right of the States to pass the laws that govern in the area of personal injury. That is the way it should be.

When we look at the Fletcher bill and some of these amendments that will probably be offered to the Norwood-Dingell-Ganske bill, what we see is an effort to federalize these kinds of issues that traditionally have been the rights of our States.

I know that the members of the Texas legislature are proud of the patient protection legislation that they passed. I know that they believe in States' rights, and I think it would be wrong in an effort by those who would seek to carve out a special exception for the managed care industry to try to federalize a cause of action to create a Federal cause of action that would be able to be tried separate and apart from the protections of law in every State in this country.

That is what this debate is all about: are we going to hold insurance companies who have managed care health insurance plans accountable on the same basis as every other business and individual in our respective States are held accountable and responsible. I hope that when it comes to the debate this Thursday or Friday, that the point of view that I am expressing will prevail because it is consistent with States rights, with the best protections for our patients; and it will get us back to the point where patients and their doctors practice medicine and not insurance companies.

Mr. PALLONE. Mr. Speaker, I thank the gentleman; and I know that he raises a number of points. I think one of the major things I do need to stress, and again because I have two colleagues here from the State of Texas which was the first State to pass a really good Patients' Bill of Rights, it is very unfortunate that the Fletcher bill, the Republican leadership bill, would seek to preempt State laws like those in Texas; and I think this is another indication that the purpose of the Fletcher bill is not to provide for greater protections for people who are in HMOs, but rather to weaken existing protections and essentially kill the effort we have here to have a strong Patients' Bill of Rights.

There is no better manifestation than the fact that the Fletcher bill preempts stronger State laws that protect patients. The Supreme Court made it clear that patients can seek compensation in State courts; yet this Republican bill effectively blocks action in State court and forces patients to pursue these limited remedies in Federal court, which is a much more difficult place to achieve relief. Going to Federal court is not easy. It costs more, it takes longer, and it is a much more difficult place to get any kind of relief.

As the gentleman says, the Fletcher bill continues to shield the HMOs from accountability in State courts where doctors and hospitals are currently held accountable. It is real unfortunate because as the gentleman said, what we have been trying to do with the Patients' Bill of Rights is extend the kinds of protections that exist in Texas to everyone throughout the country, particularly those people who, as the gentleman says, are under ERISA right now, a majority of Americans, who do not even receive protections if they happen to be in Texas or another State which happens to have these good laws.

Mr. Speaker, I yield to the other gentleman from Texas (Mr. LAMPSON), who also has been in the forefront on this and other health care issues.

Mr. LAMPSON. Mr. Speaker, I thank the gentleman from New Jersey (Mr. PALLONE). It has been interesting listening to the gentleman and also the gentleman from Texas (Mr. TURNER), my close neighbor from southeast Texas, talk about this most important issue and the concern we all have about bringing the Patients' Bill of Rights to the floor of the House of Representatives.

I think my colleague from Texas has been too modest. He did not talk about the fact that it was he who played a significant role in the development of that legislation in the Texas senate. It is a lot of his words that became the law in the State of Texas. For him then to be able to have the ability to come to the United States House of Representatives and try to craft the same kind of legislation that he was able to mold in our great State I think is significant. I am proud of him and his

service, and I am proud of the fact that he had the concern of people then in his mind when he tried to fix the problems that we faced in the State of Texas and now has the ability to come here to the United States House of Representatives and try to do the same thing for all of citizens of our country because this is a most, most important concern for everyone in this country.

Mr. Speaker, we need to live up to the promises that we have made to the American people. Bring this truly bipartisan Patients' Bill of Rights that will put medical decision-making back into the hands of physicians and patients here to the floor of the House of Representatives and let us have this debate properly.

I know that we passed it overwhelmingly last year, and it got hung up in a conference committee where there was an intentional effort to appoint those people who had voted against the bill to guarantee that it would not move and it would not become the law of this land and that it would not help people, like a lady who was a friend of mine who was a schoolteacher in Needlewood, Texas, Regina Cowles. She contacted our office after she learned that she had been diagnosed with breast cancer. She found a treatment for that cancer that was growing in her body in Houston, but her insurance company said that that was one particular treatment that they did not recognize, and that they were not going to pay for it. If she wanted to have it, she had to do it on her own.

That was one of many stories that I had heard, and my office became involved, and other offices as well became involved; and several months went by, but ultimately Regina was able to get that treatment that she needed. But unfortunately, it was too little too late, and she died of that ailment.

I wondered then how many more people were going to have to die before we brought this issue to the people's House and resolved it; that we get our colleagues to realize that we are playing not with words on paper, but with people's lives. And to act on it. To change it, to make it right for me and you, everyone that is watching here.

Mr. Speaker, I guess it came home to me in two ways. One of them was one day that I spent, and the gentleman from Texas (Mr. TURNER) talked about the time doctors spend in trying to precertify patients based on what insurance companies will determine they are willing to pay to the doctor to make that treatment possible. I periodically do these programs called Worker for a Day, and one day I was working at a cardiologist's office in Texas, and the doctor had me spend some time with one of his aides in the office making telephone calls to insurance companies to precertify the patients that had come to his office for treatment. I was flabbergasted, to say the least. I spent a significant amount of time talking with people, and I intentionally asked what their background was; and oftentimes I was talking with people who had no medical training and they were making the decision as to whether Dr. de Leon would be able to treat the patients who walked into his office complaining about a particular problem.

It does not take very long to realize that is not the way that these decisions need to be made in this country. I do not want someone who has not been to medical school or some particular program that gave them some serious knowledge about medical care, health care, telling a doctor what is going to happen in my life if I need help. I want a qualified health care professional making the decisions that are going to allow me to live and to allow me to live the kind of quality life that I want to be able to live.

I quickly became involved in this piece of legislation following that. It was not long after that I had another incident occur. This time it happened within my own family. I had two different doctors tell my daughter that she was in need of an operation. My own insurance company, the one that represents us here in the House of Representatives, said no, that is cosmetic surgery, we are not going to pay for it. Two different doctors said it was important for her to have this operation.

Well, I did everything that I could possibly do to help my daughter, and she got her operation and she is fine and the insurance company relented. But it made me wonder, what if most people, as most people are in this country, not as aggressive as I am or was in the case of my own daughter and fought for a week or 10 days or whatever it took me before we got the agreement to go forward with that operation. How many of them will take the answers that they get the first or second or third time and put it off and say, well, that is the rule and I guess I will have to go and mortgage my home to make this happen because I want my daughter to have the chance that other people's daughters will have in growing up.

Those are not decisions that we need to be making in our lives. When someone works hard, does the right thing, provides for their families, makes sure that they have insurance coverage for catastrophic problems that face them, and then are turned down because someone decides that it is cosmetic or experimental or that it does not match their specific criteria that they laid down on their papers based on what profit they can make for their company, that is absolutely wrong and we cannot stand for it in the United States of America.

Managed care reform is an issue of the absolute, utmost importance. As more and more stories about HMOs denying care are publicized, it brings it to the forefront of what we need to do to pass this legislation. The public and health care providers have witnessed firsthand that while managed care organizations such as HMOs may have helped to hold down the cost of medical care, they too have frequently done so at the cost of denying needed care to patients.

Unfortunately, the Republican leadership continues to block consideration of the Ganske-Dingell-Norwood Patients' Bill of Rights that passed overwhelmingly, I think 275 votes last year. They continue to stall on a vote and have introduced their own bill, the Fletcher bill, that the gentleman from Texas (Mr. TURNER) and the gentleman from New Jersey (Mr. PALLONE) have talked about in an attempt to poison this Patients' Bill of Rights that we have been trying so hard to pass.

The assertion that they have crafted a responsible plan is simply untrue. Their plan prevents doctors from disclosing all medical options to patients. It creates a review process that is stacked against the patient, and it removes medical decision-making power from the hands of doctors and patients.

Mr. Speaker, I said a minute ago, 275 members of the House of Representatives voted for a Patients' Bill of Rights that would create a system of accountability for insurance companies and HMOs that routinely and unfairly deny care to patients. This year we again consider legislation that would hold HMOs liable for denial and delay of care. If insurers are going to practice medicine and determine the necessity of care, then they will be held accountable for their decisions.

I join my colleagues and I again want to praise the gentleman from Texas (Mr. TURNER) for the work that he did in Texas and the gentleman from New Jersey (Mr. PALLONE) for continuously bringing this important issue before us.

I urge my Republican colleagues and President Bush both to quit stalling and do what Americans want and need, pass and sign a meaningful patient protection bill that puts control of medical decisions back into the hands of patients and doctors. I thank the gentleman for allowing me to participate this evening.

□ 2200

Mr. PALLONE. I want to thank my colleague, because I think, number one, when you give examples and particularly one from your own personal life, it really highlights and makes people understand, both our colleagues and the public, what we are talking about and how significant it is to pass a Patients' Bill of Rights.

The other thing that my colleague from Texas did which I think is very important is that he pointed out some of the patient protections that are in the real Patients' Bill of Rights, the Dingell-Norwood-Ganske bill, and why they do make a difference. One of the concerns that I have is that, as I mentioned earlier, one of the possible amendments that we may get or that the Republican leadership may make in order and try to push if this bill

comes up on Thursday is replacing the patient protections in the Dingell-Norwood-Ganske, the bipartisan bill, with the patient protections in the Fletcher bill, in the Republican leadership bill. I assure my colleagues that effectively there are no significant protections in the Fletcher bill.

If I could just contrast that a little bit to give us an idea of the differences, some of those differences were mentioned by the gentleman from Texas. He talked about the gag rule and how under the Fletcher bill HMOs could continue to tell physicians that they are not entitled to tell their patients about procedures or medical activity or medical equipment or stay in a hospital or any kind of medical procedure that the HMO does not plan to cover. It is called the gag rule because you never find out what the doctor really thinks you should have done to you because he is not allowed to tell you if the HMO says he is not allowed to.

The other one that comes to mind is the financial incentives. Right now a lot of the HMOs have financial incentives so that if the HMO wants to give the physician a little more money because he is not providing as much care or not having as many operations or not having his patients stay in the hospital for too long, they can provide a financial incentive to him at the end of the month so he gets more money if those things occur, which is an awful thing; but it is the reality with many of the plans today.

The other thing that I think was so important is when the gentleman from Texas (Mr. LAMPSON) talked about how some of these things work out in terms of actual protections for particular kinds of procedures. For example, one of the concerns is that access to specialty care is severely limited both under current law and can be limited by the HMO under the Fletcher bill. The Fletcher bill really does not do much to provide access to specialty care. That can manifest itself in a number of ways. For example, with regard to some of the patient protections for women. In the real Patients' Bill of Rights, the Dingell-Norwood-Ganske bill, you get direct access to OB-GYN care. But the Fletcher bill allows plans or HMOs to require prior authorization for items of services beyond an annual prenatal or perinatal exam.

The Fletcher bill also creates a loophole which allows plans to avoid the requirement of saying that you can go directly to the OB-GYN. It lets the HMOs off the hook for providing direct access to OB-GYN care if they merely allow patients a choice of primary care providers that includes at least one OB-GYN provider.

There are a lot of other differences with regard to care that impacts women. Breast cancer treatment, for example; the hospital length of stay. The Dingell-Norwood-Ganske bill requires coverage for the length of the hospital stay the provider and patient deem appropriate for mastectomies and lymph node dissections for the treatment of breast cancer. The Fletcher bill omits this coverage as well as coverage for second opinions.

Emergency care, another example that affects not only women but anyone. The Fletcher bill uses a prudent health professional standard rather than the prudent layperson for neonatal emergency care. Let me give Members an example. Right now, as many people in HMOs know, they often cannot go to the emergency room of the hospital closest to them but rather may have to travel 50, 60 miles away to a different hospital. What we are saying is that in the case of an emergency, if the average person would think that they cannot travel that distance and they have to go to the local hospital because otherwise, for example, if they have chest pain and they think that they are having a heart attack, well, that is the prudent layperson's standard, which basically says that if the average person would think that if I get chest pains of this severity that I have got to go to the local hospital rather than 50 miles away, then I go to the local hospital and the HMO has to pay for it. You do not have that kind of standard in the Fletcher bill with regard to neonatal emergency care.

There are so many other cases. Clinical trials. An astonishing number of women suffer from Alzheimer's, Parkinson's, cystic fibrosis and other debilitating disorders. Under the Dingell-Ganske-Norwood bill, it covers all FDA clinical trials. But the Fletcher bill, the Republican leadership bill, only covers FDA cancer trials, preventing women with other serious conditions from receiving potentially lifesaving care. There are so many examples like this. The bottom line is the Fletcher bill makes it very difficult to access specialty care.

We used another example the other night on the floor about pediatricians. Under the Dingell-Norwood-Ganske bill, you have direct access to a pediatrician for your child. You do not have to have prior authorization. But you also have the opportunity to go to a pediatric specialist which now, I have three children, and now you often go to a pediatric specialist rather than a pediatrician, who is almost like a general practitioner. What happens under the Fletcher bill is you do not have that option. So a lot of these specialty-care initiatives which are a very important part of the patient protections simply do not exist under the Republican leadership alternative.

As I said, what we are hearing is that it is very likely that the Committee on Rules tonight will allow all these different provisions in the Fletcher bill that weaken patient protections to be included as amendments and voted on in an effort to try to achieve a bill that is a lot weaker than the real Patients' Bill of Rights. I could go on, but I see that another colleague from Texas is here and she again has been here many nights talking about the Patients' Bill of Rights and has been a champion on the issue. I yield to her at this time.

Ms. JACKSON-LEE of Texas. I thank the gentleman. I could not help, as I was viewing the presentation on this debate, to remember that we were together just last week, I believe, making the point that the debate on this bill is long overdue. The reasons for this bill, the purpose of going forward is so clear that I question whether or not the will of the American people really is being understood by this body. I think when the American people are frustrated, it is because they have made in every way their voices or their beliefs known to us about the fairness in health care as the Ganske-Dingell bill evidences, and they just do not know why we cannot get it done.

We understand that this bill is likely to come to the floor of the House at the end of the week. I hope so. As you noted, I am delighted to join my colleagues from Texas who have obviously already spoken about how this bill has worked and how it has been effective in the State of Texas. First of all, there has been no increase in premiums and the increase in premiums nationwide generated without a Patients' Bill of Rights. We have not seen an increase in the uninsured which the opponents of the bill have represented would occur. We have not seen a proliferation of frivolous lawsuits. We have not even seen a proliferation of lawsuits under this legislation. It comes to mind that there have been maybe about 27, all meritorious, over the 4 years that the State of Texas has had the opportunity to hold HMOs accountable.

So the real question for the House leadership is why. Why, since this bill in its present form, with a few enhancements, meaning the Ganske-Dingell bill, passed two terms ago, why can this not be the bill that we all conclude is the right direction to go? What is the purpose of putting forward a bill with the idea that it represents an alternative when that is not accurate? Because the Fletcher bill has a number of poison pills. It has medical savings accounts. Not to say those are not meritorious legislative initiatives that this body should not address, but what the American people want most of all now is that when they do have an HMO, which most of the employers are involved in and utilize to create coverage for their employees, that that HMO does not intervene, intercede and stop good health care and procedures for you or your loved one. How clear can we get?

I, when we spoke the last time, noted a lot of tragic stories: the woman in Hawaii who could not get care in Hawaii while she was there because her HMO denied it. She had to get on a plane to Chicago, and my recollection of that final result is that she did not survive, because they denied her the ability to secure health care in Hawaii, because she was not from Hawaii. The tragedy of being denied the most accessible emergency room; the tragedy of

being denied pediatric specialists; the unseemly result of not allowing a woman to choose an OB-GYN specialist as her primary caregiver. That is allowed in the Ganske-Dingell bill.

There are so many positives that the American people have decided that they need and want that are in the bill that we are proposing and supporting, the real Patients' Bill of Rights, along with the array of diverse medical groups that are supporting it, including, I think, one of the strongest medical groups, of course, is the American Medical Association, that has not moved from its position that this is the only bill that they will support and that we should support, and, that is, to ensure the sanctity, if you will, of the patient-physician relationship.

I would like to thank my good friend for his leadership, and I could not help but join you in hoping that someone might hear us this evening. And, of course, sometimes our words are distant. They fall distant because we are here in Washington. But I can tell you in the conversations that I have had with my constituents who are physicians, the difficulty that they have had in plainly giving good health care, in making the decisions on good medicine, the stories that they have generated, the frustration that they have experienced, the fact that HMOs are able by bureaucrats and computers to deny services to patients is a difficult and overwhelming experience and has changed the practice of medicine to the point of making it distasteful, because our friends who are doctors are there to heal and to help. And lo and behold in the middle of that healing comes a red stop sign that says that there is no more medicine at this door, no more treatment for this patient, no more experimental opportunities to make that patient improve. I think enough is enough.

I would hope that my friends in this House would take heed of the voices of the American people, physicians everywhere, employers everywhere who desire that the HMO coverage that they have for their employees is the best; and might I say we of course have fixed that aspect of concern dealing with employers, and we are ready to move forward. I would hope that they would listen to us on that very issue.

I would note as I close just simply, I brought it up the last time, is the disparity in health care in many of our rural and urban areas and in many of our minority communities. We hear many times some of the higher statistics are certain diseases in one community versus another. Then it makes it very difficult if a bureaucrat tells a physician who treats a particular ethnic group that has a high percentage of a certain disease that you must care for them in one certain way, sort of the boxcar way as opposed to responding to the disparate needs of Americans in their different environmental backgrounds. That will be prevented if we do not pass the Dingell bill and pass the so-called alternative. I thank the gentleman for giving me this time.

Mr. PALLONE. I want to thank the gentlewoman for coming down again tonight as she has so many other times to express her opinion on the Patients' Bill of Rights. I know it is tough for us because we keep hearing that this bill is going to come up. We are hearing again that it is going to come up this Thursday.

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I guess we are at the point we will not believe it until it actually occurs. The gentlewoman mentioned a few points that I have to bring up, because we did not include them as part of the debate tonight, and I think they are very important.

One is the number of health professional groups that support the real Patients' Bill of Rights, the Dingell-Norwood-Ganske bill. The gentlewoman mentioned the American Medical Association, the Nurses Association, all the specialty doctors groups. I think there are something like 700 different groups, all the major health care professional groups.

The bottom line is it is because they are very concerned about the fact they cannot provide care now with the way some of the HMOs operate, and they want the freedom and sort of the ability, we call it the American way, to be able to provide the best care that they think is necessary for their patients.

The other thing that the gentlewoman mentioned, which I think is so important, is, again, the Texas experience; the fact that even though President, then Governor, Bush complained at the time when this legislation was being considered in the Texas legislature that it was going to increase costs for health insurance and was going to cause all this litigation. None of that turned out to be true.

The gentleman from Texas (Mr. TURNER) mentioned earlier that the increased costs for health insurance in Texas is half of the national average. The gentlewoman mentioned approximately 20 or so lawsuits that have been brought in 4 years, which is nothing. What is that, that is like five per year. Because basically what happens is now people have the ability to go to an external independent review to overturn the HMO if they did the wrong thing. We have had almost 1,500 cases of that, and they are handled easily and that is the end of it.

The other thing the gentlewoman mentioned, which I think is so important, I said earlier this evening that my fear is the Committee on Rules, when they meet later this evening, I think they are supposed to go in at midnight, which says a lot about the procedure around here with the Republican leadership, that they may put in order some of these poison pills from the Fletcher bill.

I mentioned earlier in Congress Daily they said likely amendments include a so-called access package, a proposal seeking to expand insurance through broader access to medical savings accounts and creation of association health plans. Further, it says in Congress Daily, it is possible there will be an amendment to impose caps on medical malpractice awards.

Now, I do not happen to like the medical savings accounts. I think they are sort of a ruse. But whether or not you approve of MSAs or approve of caps on malpractice or approve of these association health plans, the bottom line is there is no reason why these need to be included in this legislation. We know that the majority of the House supports the Patients' Bill of Rights, and they support it because of the patient protections. We do not need to deal with these other much more controversial issues like malpractice and medical savings accounts in the context of this bill.

The only reason the Fletcher bill includes some of those things and the only reason why those parts of the Fletcher bill would be considered under the procedure is because the Republican leadership wants to throw them in, mess this whole thing up, and create a situation where it goes to conference, like it did last time, between the House and Senate, and nothing happens because there is too much controversy over all these other things that are unrelated. That is what I am fearful of, to be honest.

I know we do not have a lot of time left here tonight, but I would, again, appeal to the Republican leadership: All we are asking for is to bring this bill up and allow us a clean vote on the real Patients' Bill of Rights. You can have all the other votes you want, but let us have a clean vote on this bill.

I am confident that if that happens, this bill will pass, because I know that almost every Democrat will vote for it, and that there are probably a significant number of Republicans that will as well.

But I am fearful, honestly, that we are not going to have that opportunity, because we do not control the process. The Republican leadership controls the process. They are particularly mad right now. As the gentlewoman knows, their wrath is against some of the Republicans that are willing to join us and support the real Patients' Bill of Rights, they are being criticized, hauled down to the White House and being told you are not a real Republican. This is not about who is a real Republican or who is a real Democrat, this is about who is a real American and who is going to stand up for the people that need help.

Ms. JACKSON-LEE of Texas. I thank the gentleman very much. As the gentleman was speaking, I was thinking of one point I wanted to add. You have heard those of us from Texas speak about the Texas law, and we are very proud that bill passed out of the State legislature, the House and the Senate. Of course, the gentleman realizes the bill was not signed by the President, it

was simply allowed by our laws in the State of Texas to go into law because there was no action. However, I think the evidence of its success should be very evident for our President, and he would see that we could live with accountability and in fact not have a disastrous situation.

But I do want to note for those who are thinking, well, you have it in the State of Texas, but in many states that do have some form of an HMO accountability plan, it does not cover everyone. So the reason why it is important for this to be passed at a Federal level is that when you pass it at a Federal level, all states must be in compliance. The Patients' Bill of Rights then becomes the law of the land, and whatever your HMO is, you have the opportunity, whether you are in Iowa, in New Jersey, California, New York or Texas, that you have the opportunity to ensure that there is accountability for the HMO.

I think that is very important, because the question has been raised, well, a number of states already have done it, why do you have to do it? Because you have states that have done it, but do not have full coverage, and you have states that have not done it and, therefore, it is important for Federal law for us to act.

Mr. PALLONE. I agree. Reclaiming my time, the bottom line is that even in the states that have strong patient protections, like Texas, a significant amount of people, sometimes the majority, are not covered by those protections, because of the Federal preemption.

I would say right now there are only about 10 states that have protections as strong as Texas, my own being one of them. But the other 40, some have no protections, some have much weaker laws. So this notion that somehow everybody out there is already getting some kind of help is not really accurate for most Americans. That is why we really need this bill.

I think we only have a couple of minutes, so if I could conclude and thank the gentlewoman and my other colleagues from Texas for joining us tonight in saying that we are going to be watching. We will be here again demanding that we have a vote on the real Patients' Bill of Rights. Let us hope we have it on Thursday. But, if we do not, we will continue to demand that the Republican leadership allow a vote.

## MISSILE DEFENSE

The SPEAKER pro tempore (Mr. KELLER). Under the Speaker's announced policy of January 3, 2001, the gentleman from Colorado (Mr. MCINNIS) is recognized for 60 minutes.

Mr. MCINNIS. Mr. Speaker, I know it is late in the evening, but this evening I wanted to visit with you about an issue that I think is inherently important to every citizen of America, and not just the citizens of America, but to the world as a whole, to every country in this world as we go into the future. Tonight I want to speak to you about a subject that I think we have an obligation to use some vision about, to think about future generations, and what this generation needs to do not just to protect our generation, but to protect future generations, to give future generations the type of security that as American citizens they deserve, that as American citizens they can expect their elected officials, they can obligate their elected officials to provide for them. Tonight I want to visit about missile defense.

Now, we have heard a lot of rhetoric in the last few days about missile defense. Well, we do not need it. It is going to escalate the arms race. Why, building a defense to protect your country and to protect your citizens from an incoming missile is not something we should undertake. In fact, the recommendation seems to be, leave our citizens without a shield of protection.

I take just exactly the opposite. I think every one of us have an obligation to protect our citizens with a shield that will mean something, not simple rhetoric.

I have to my left here a poster, and tonight I am going to go through a series of posters. If you will pay close attention, I think you will find that these posters advocate a strong case of why this country, without hesitation, should move forward immediately to engage in a missile defense system, to put into working order with other countries some kind of an understanding that the United States of America feels it has an inherent obligation to protect its citizens with some kind of shield.

Let me go over a couple of points here. First of all, to my left, I call this poster ''probability of events.'' When you look at it, you see my first box, my first yellow box is called intentional launch. There I am referring to an intentional launch of a missile against the United States of America. I call this a probability.

I have the next box called accidental launch. I call this a probability. At some point in the future, against the United States of America, some country, unknown to us today as far as which country will do it, but the facts are that some country will attempt to launch a missile against the United States of America. That is why it is our obligation as elected officials representing the people of America, who swear under our Constitution to protect the Constitution, which within its borders obligates us to provide security for the citizens of the United States, that is why it will be our responsibility to begin to provide that security blanket for the American people and for our allies, that when this intentional missile launch comes, we will be prepared/:

The second thing I speak about is an accidental launch. Do not be mistaken. We know the most sophisticated, most well-designed aircraft in the world, take a civilian plane, a 747, once in awhile they crash. Take the most sophisticated, the finest invention you can think of, whether it is a telephone, whether it is a radio, whether it is a computer, whether it is an electrical system; there are accidents. In fact, I am not so sure that we have had much of any invention that at some point or another does not have an accident.

It is probable that at some point in the future some country, by mistake, will launch a missile towards the United States of America. And, right now, as you know, an accidental launch against us, number one, we would not know whether it was accidental or not, and, two, the only defense we have today, the only defense we have today against an accidental launch, is retaliation. And what is retaliation going to bring? Because of an event, a horrible consequence of a missile launched against us by accident, by accident, our retaliation could initiate the Third World War, the most devastating disaster to occur in the history of the world.

Yet we can avoid this, because if we have a missile defensive system in place and a country launches a missile against the United States by accident, or intentionally, but here we are referring to the accidental launch, the United States of America can shoot that missile down and they can stop that war from occurring.

There are plenty of other less severe, significantly less severe measures, we can take against a country that accidentally launches against us. Retaliation is not one of them that we should take, but retaliation is the only tool left today. I can assure you that the President of the United States, whatever party they belong to, if some country by accident launches a nuclear missile into Los Angeles or New York City or into the core of this country, into the middle of Colorado, where my district is located, the likelihood is that the President would retaliate forthwith.

Now, I had an interesting thing happen to me this evening while I was waiting speak, listening to my colleagues. I was outside talking to a couple of officers, Officer Conrad Smith and Officer Wendell Summers. Good chaps. I was out there visiting with them, and they brought up an interesting point.

They said, ''What are you going to speak about tonight, Congressman?''

I said, ''I am going to speak about missile defense, like an intentional launch against our country, or an accidental launch against our country.''

Do you know what Officer Smith said? I did not think about it, but it is so obvious. Officer Smith said to me, ''Do you know what else we could use a missile defense system for? It is space junk. Like, for example, Congressman, if a space station or like the Mir Space Capsule is reentering the United States, we could use our missile defense to destroy that in the air, so that